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A multi-centre study of interactional style in nurse specialist- and physician-led Rheumatology clinics in the UK

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ABSTRACT

Background: Nurse-led care is well established in Rheumatology in the UK and provides follow-up care to people with inflammatory arthritis including treatment, monitoring, patient education and psychosocial support.
Aim: The aim of this study is to compare and contrast interactional style with patients in physician-led and nurse-led Rheumatology clinics.
Design: A multi-centre mixed methods approach was adopted.
Settings: Nine UK Rheumatology out-patient clinics were observed and audio-recorded May 2009–April 2010.
Participants: Eighteen practitioners agreed to participate in clinic audio-recordings, researcher observations, and note-taking. Of 9 nurse specialists, 8 were female and 5 of 9 physicians were female. Eight practitioners in each group took part in audio-recorded post-clinic interviews. All patients on the clinic list for those practitioners were invited to participate and 107 were consented and observed. In the nurse specialist cohort 46% were female; 71% had a diagnosis of Rheumatoid Arthritis (RA). The physician cohort comprised 31% female; 40% with RA and 16% unconfirmed diagnosis. Nineteen (18%) of the patients observed were approached for an audio-recorded telephone interview and 15 participated (4 male, 11 female).
Methods: Forty-four nurse specialist and 63 physician consultations with patients were recorded. Roter's Interactional Analysis System (RIAS) was used to code this data. Thirty-one semi-structured interviews were conducted (16 practitioner, 15 patients) within 24 h of observed consultations and were analyzed using thematic analysis.
Results: RIAS results illuminated differences between practitioners that can be classified as 'socio-emotional' versus 'task-focussed'. Specifically, nurse specialists and their patients engaged significantly more in the socio-emotional activity of 'building a relationship'. Across practitioners, the greatest proportion of 'patient initiations' were in 'giving medical information' and reflected what patients wanted the practitioner to know rather than giving insight into what patients wanted to know from practitioners. Interviews revealed that continuity of practitioner was highly valued by patients as offering the benefits of an

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established relationship and of emotional support beyond that of the clinical encounter. This fostered familiarity not only with their particular medical history, but also their individual personal circumstances, and this encouraged patient participation. In contrast, practitioners (mis)perceived waiting times to have a greater impact on patient satisfaction. However, practitioner interviews also revealed that clinic structure is often outside of the practitioner control and can undermine the possibility of maintaining patient–practitioner continuity.

Conclusions: This research enhances understanding of nurse specialist consultation styles in Rheumatology, specifically the value of their socio-emotional communication skills to enhance patient participation.

What is already known about the topic?

- Recent emerging research has provided limited but robust evidence to support nurse-led clinics (NLC) in the management of Rheumatoid Arthritis and co-morbidity detection with NLC having higher 'general satisfaction' than doctor-led clinics (DLC).
- Although CNSs are able to draw on this research to articulate the value of their work, it seems they have more difficulty unpacking and describing the complexity of the care they give.

What this paper adds

- This research presents a more comprehensive assessment of consultations through systematic analysis of clinic audio-recordings informed by clinic observations and practitioner and patient reflections.
- This paper demonstrates that socio-emotional communication and relationship building, at which CNS excel, has clinical relevance in relation to measurable outcomes of quality of care and our study can evidence important, but previously invisible, CNS skills in this area.

Nurse-led care has evolved against a background of a rising number of long-term conditions associated with an ageing population which increases patient expectations and need in relation to support for self-care. Workforce shortages and increased demands on health care utilization make specialist nursing an attractive model of health care provision. As a result, nurses have been trained for roles which either substitute, or complement, physician led care in the UK, Europe, and beyond (US, Canada, Australia, Russia, South Africa). A number of systematic reviews have addressed the impact of specialist nurse-led care focussing on outcomes.

Martinez-Gonzalez et al. (2014) identified twelve randomized controlled trials (RCTs) comprising 22,617 patients specifically focussing upon the impact of shifting care traditionally delivered by physicians to nurse practitioners in primary care. Three quarters of these studies were conducted in Europe and nurse-led care was provided for patients with heart or lung disease, diabetes mellitus, digestive or skin disease, or infectious diseases. Three trials evaluated nurse practitioners assessing and treating patients with a range of acute and minor complaints. The authors noted a wide range of outcome measures, risk of biases, and variable follow-up (maximum 1–2 years), which is not surprising given the diversity of the patient populations. Nonetheless, the available evidence, including three meta-analyses for the outcomes (blood pressure, total cholesterol, and glycosolated haemoglobin concentration), indicates equivalent outcomes and a significantly greater reduction in systolic blood pressure associated with nurse-led care.

Processes of care are less well understood. A Canadian report (Health Quality Ontario, 2013) classified RCTs according to whether the intervention constituted physician–nurse substitution ($n = 1$) or nurses and physicians delivering shared care (substituting and supplementing care) versus usual care in primary-care-based chronic disease management ($n = 6$). Variations in the way specialist nursing was implemented made comparisons difficult but there was consistent low-to-moderate-quality evidence to support equivalence of outcomes with physician–nurse substitution. Shared care showed an overall improvement in disease-specific measures and patient satisfaction. Process indicators suggested that nurse-led care was associated with greater adherence to evidence-based guidelines informing clinical examination and medicines management but otherwise consultation styles and interpersonal processes were not examined.

Physicians and nurse specialists in the UK offer a multidisciplinary approach to outpatient care, running clinics side-by-side and able to access each other's expertise. Despite wide-scale adoption, evidence of the effectiveness of nurse specialists and their clinics is limited. Recent work has addressed this gap with two recent multi-centre studies undertaken in the UK of effectiveness and economic value (Ndosi et al., 2013) and, in France, of co-morbidity management (Dougados et al., 2015). Results provide robust evidence to support nurse-led clinics in the management of Rheumatoid Arthritis and co-morbidity detection with nurse-led clinics having higher 'general satisfaction' than physician-led clinics (Arvidsson et al., 2006). The findings of the UK multi-centre RCT were consistent with those from the only other large scale costs study – in the Netherlands – which demonstrated nurse-led clinics produced equivalent outcomes at lower unit cost (Tijhuis et al., 2002, 2003) Recent work in Sweden also showed that patients undergoing biological therapy can be safely monitored more cost-effectively by a nurse-led Rheumatology clinic (Larsson et al., 2014; Larsson et al., 2015).